[redacted]

Excellus
Central New York
Region

An Independent Licensee of the
BlueCross BlueShield Association

P.O. Box 4979 • Syracuse, N.Y. 13221 • TDD (315) 448-6764 • 1-800-552-0092

SECTION ONE

Before signing claim form, please read the following:

1. In order for this claim to be processed, an itemized bill ***must*** be attached. **Failure to do so will result in the claim being denied.** It should include the following:
   - The provider's name and address (hospital, doctor, lab, pharmacy, etc.)
   - Date(s) of service
   - Patient's name
   - Charges for each service
   - Prescription receipts must include the prescription number, physician and name
   - Diagnosis or symptoms
2. If another insurance carrier or Medicare had made payment on this service, their explanation of benefits form must be attached.
3. Only ***one*** patient may be included on a claim form.
4. There is no limit to the amount of bills you may attach to the claim form.
5. It is recommended that you keep copies of information submitted to Excellus Blue Cross and Blue Shield for your records.

SECTION TWO

1. Patient's Last Name	First	2. Patient's Date of Birth	3. Patient's Sex ❑ Male ❑ Female

4. Blue Cross and Blue Shield ID Number (Include the three-digit prefix on your card.)	5. Total (Office use only)	6. Patient's Account Number (Office use only)

7. Subscriber's (Insured's) Complete Mailing Address	City	State	Zip

8. Subscriber's (Insured's) Last Name	First	9. Was Condition Related to? Employment ❑ Yes ❑ No Auto Accident ❑ Yes ❑ No

10. Has Bill Been Paid by You? ❑ Yes ❑ No	11. Group Number	12. Symptoms or Diagnosis	13. Date and Time Symptoms Started or Accident Occurred

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Contract Holder _____ Date _____

SECTION THREE–FOR OFFICE USE ONLY

Total	COB	COB PD	Total	COB	COB PD

P 1 Name	Type	Co.	DX	P 2 Name	Type	Co.	DX

	DATE	POS	TOS	PROC	M	MI	#SER	$	ACT CODE		DATE	POS	TOS	PROC	M	MI	#SER	$	ACT CODE
1										1									
2										2									
3										3									
4										4									
5										5									
6										6									
7										7									
8										8									
9										9									
10										10									
11										11									
12										12									

HR _____ MN _____ Ref Phy _____ RCN _____